2013 BENEFITS SUMMARY

AVMED POS PLAN		
This Schedule of Benefits reflects the higher provider and prescription co-payments for 2013. This is not a contract, it's a summary of the plan highlights and is subject to change. For specific information on Benefits, Exclusions and Limitations please see your Summary Plan Description. FOR ADDITIONAL INFORMATION, PLEASE CALL: 1-800-68-AVMED (1-800-682-8633), or visit the AvMed website at www.avmed.org/go/mdpht.		
SCHEDULE OF BENEFITS	COST TO MEMBER	COST TO MEMBER
	In-Network	Out-of-Network*
LIFETIME MAXIMUM	Unlimited	Unlimited
CO-INSURANCE LEVELS	Plan pays 100%; Member Pays 0%	Plan pays 70% of Maximum Allowable Payment (MAP); Member Pays 30% of the MAP after Deductible
CALENDAR YEAR DEDUCTIBLE		
Individual (per contract year)	Not Applicable	$200 per individual
Family (per contract year)	Not Applicable	$500 per family
Deductible does not apply toward the Out-of-Pocket Maximum Individual Calculation: Family members meet only their individual deductible and then their claims will be covered under the plan co-insurance; if the family deductible was met prior to their individual deductible being met, their claims will be paid at the plan co-insurance.		
OUT-OF-POCKET MAXIMUM (Per Calendar Year)		
Individual Maximum	Not Applicable	$1500 per individual
Family Maximum	Not Applicable	Not Applicable
Individual Calculation: Family members meet only their individual Out-of-Pocket and then their claims will be covered at 100%.		
PHYSICIAN SERVICES		
Services at Physician's offices include, but are not limited to:		
Primary Care Physician's Office Visit	$15 per visit	30% of the MAP, after Deductible
Specialty Care Physician's Office Visits, Consultant and Referral Physician's Services	$30 per visit	30% of the MAP, after Deductible
Allergy Injections	No charge	30% of the MAP, after Deductible
Allergy Skin Testing	$30 per visit	30% of the MAP, after Deductible
PREVENTIVE CARE		
Preventive Care (as required by the Patient Protection Affordable Care Act "PPACA")	No charge	30% of the MAP, after Deductible
MAMMOGRAM, PSA, PAP SMEAR		
Preventive care related services (i.e. "routine" services)	No charge	30% of the MAP, after Deductible
Diagnostic related services (i.e. "non-routine")	Subject to the plan's x-ray and laboratory benefit, based on place of service	Subject to the plan's x-ray and laboratory benefit, based on place of service

2013 BENEFITS SUMMARY

AVMED POS PLAN		
SCHEDULE OF BENEFITS	COST TO MEMBER	COST TO MEMBER
	In-Network	Out-of-Network*
INPATIENT HOSPITAL SERVICES		
Pre-Certification of Hospital Confinements	Handled by admitting physician	Pre-certification required or benfits will result in a $500 penalty. This is the responsibility of the member, not the providers
Hospital inpatient care includes: Room and board – unlimited days (semi-private)	No charge	30% of the MAP, after Deductible
Private Room	Limited to the semi-private room negotiated rate	Limited to the semi-private room rate
Special Care Units (ICU/CCU)	No charge	30% of the MAP, after Deductible
Inpatient Hospital Physician's Visits/Consultations	No charge	30% of the MAP, after Deductible
Inpatient/Outpatient Hospital Professional Services	No charge	30% of the MAP, after Deductible
OUTPATIENT FACILITY SERVICES		
Operating Room, Recovery Room, Procedures Room, Treatment Room and Observation Room	No charge	30% of the MAP, after Deductible
Diagnostic Testing	No charge	30% of the MAP, after Deductible
EMERGENCY AND URGENT CARE SERVICES		
PCP's Office	$15 per visit	30% of the MAP, after Deductible
Specialist's Office	$30 per visit	30% of the MAP, after Deductible
Hospital Emergency Room	$50 per visit (waived if admitted)	$50 per visit (waived if admitted)
Outpatient Professional Services (radiology, pathology, ER physician)	No charge	No charge
Urgent Care Facility or Outpatient Facility	$50 per visit (waived if admitted)	$50 per visit (waived if admitted)
LABORATORY/ RADIOLOGY SERVICES		
(includes pre-admission testing)		
Physician's office visit	No charge	30% of the MAP, after Deductible
Outpatient hospital facility	No charge	30% of the MAP, after Deductible
Independent x-ray and/or laboratory facility	No charge	30% of the MAP, after Deductible
ADVANCED RADIOLOGICAL IMAGING		
(i.e. MRI, MRA, CAT scan , PET scan, etc.) The scan co-payment/deductible applies per type of scan per day		
Outpatient Facility	No charge	30% of the MAP, after Deductible
Inpatient Facility	No charge	30% of the MAP, after Deductible
Physician's Office	No charge	30% of the MAP, after Deductible
OUTPATIENT SHORT-TERM REHABILITATIVE THERAPY AND CHIROPRACTIC SERVICES		
Contract Year Maximum: 60 days for all therapy combined Includes:		
Chiropractor	$15 per visit	30% of the MAP, after Deductible
Physical Therapy, Speech Therapy, Occupational Therapy, Pulmonary Rehabilitation, Cognitive Therapy Respiratory Therapy	$30 per visit	30% of the MAP, after Deductible
Note: The Outpatient short term rehabilitation Co-payment does not apply to services provided as part of a Home Health Care visit.		

2013 BENEFITS SUMMARY

AVMED POS PLAN		
SCHEDULE OF BENEFITS	COST TO MEMBER	COST TO MEMBER
	In-Network	**Out-of-Network***
MATERNITY CARE SERVICES		
Initial visit	$30 per visit	30% of the MAP, after Deductible
All subsequent prenatal visits, postnatal visits and Physician's delivery charges (i.e. global maternity fee)	No charge	30% of the MAP, after Deductible
Delivery facility (inpatient hospital, birthing center)	No charge	30% of the MAP, after Deductible
DURABLE MEDICAL EQUIPMENT		
Contract Year Maximum: Unlimited	No charge	30% of the MAP, after Deductible
ACUPUNCTURE	Out-of-network coverage only	30% of the MAP, after Deductible
MENTAL HEALTH		
Outpatient	$15 per visit	30% of the MAP, after Deductible
Inpatient	No charge	30% of the MAP, after Deductible
Intensive Outpatient	$15 per visit	30% of the MAP, after Deductible
SUBSTANCE ABUSE		
Outpatient	$15 per visit	30% of the MAP, after Deductible
Inpatient	No charge	30% of the MAP, after Deductible
Intensive Outpatient	$15 per visit	30% of the MAP, after Deductible
DIAGNOSIS AND TREATMENT OF AUTISM SPECTRUM DISORDER		
Applied Behavioral Analysis (ABA)	$15 per visit	30% of the MAP, after Deductible
Physical, Speech, Occupational Therapy	$15 per visit	30% of the MAP, after Deductible
Calendar Year Maximum: $36,000—in and out of network, Lifetime Maximum: $200,000—in and out of network		
PRESCRIPTION MEDICATION BENEFIT — RETAIL, 30 DAY SUPPLY (**INCLUDES CONTRACEPTIVES)		
Generic	$15	30% of charges
Preferred Brand	$25	30% of charges
Non-Preferred Brand	$35	30% of charges
SPECIALTY (30-DAY SUPPLY THROUGH SPECIALTY PHARMACY)		
Generic	$10.00	30% of charges
Preferred Brand	$16.66	30% of charges
Non-Preferred Brand	$23.33	30% of charges
PRESCRIPTION MEDICATIONS - MAIL-ORDER, 90 DAY SUPPLY (**INCLUDES CONTRACEPTIVES)		
Generic	$30	30% of charges
Preferred Brand	$50	30% of charges
Non-Preferred Brand	$70	30% of charges
Generic: medication on the Prescription medication list - **Preferred Brand**: medication designated as preferred on the prescription medication list with no Generic equivalent - **Non-Preferred Brand**: medication with a Generic equivalent and/or medication designated as non-preferred on the Prescription medication list.		
* Member may be responsible for all Out-Of-Network charges in excess of the Maximum Allowable Payment (MAP).		
** There is no co-payment for Generic contraceptives, in accordance with provisions of the Patient Protection and Affordable Care Act (PPACA).		

2013 BENEFITS SUMMARY

AVMED HMO PLANS		
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SCHEDULE OF BENEFITS	AVMED HMO HIGH	AVMED HMO LOW
	COST TO MEMBER	COST TO MEMBER
LIFETIME MAXIMUM	Unlimited	Unlimited
CALENDAR YEAR DEDUCTIBLE		
Individual /Family	Not Applicable	Not Applicable
OUT-OF-POCKET MAXIMUM (Per Calendar Year)		
Individual	$1,500	$1,500
Family	$3,000	$3,000
PRIMARY CARE PHYSICIAN		
Routine office visits	$15 per visit	$30 per visit
Preventive care-routine physicals/pediatric well baby care (and other preventive services required by the Patient Protection Affordable Care Act "PPACA")	No Charge	No Charge
Pediatrician	$15 per visit	$30 per visit
SPECIALIST'S SERVICES	Open Access	Referral Required For Most Services
Office Visits	$30 per visit	$45 per visit
Annual gyn exam when performed by participating specialist	No Charge	No Charge
MATERNITY CARE SERVICES		
Initial visit	$30 per visit	$45 per visit
Subsequent visits	No charge	No charge
ALLERGY TREATMENTS		
Allergy Injections	$15 per visit	$30 per visit
Skin testing (per course of treatment)	$30 per visit	$45 per visit
HOSPITAL SERVICES - Inpatient care at participating hospitals includes:		
Room and board - unlimited days (semi-private)	No charge	$150 per day for the first 3 days, per admission. No charge thereafter.
Physicians', specialists' and surgeons' svces	No charge	
Anesthesia, use of operating and recovery rooms, oxygen, drugs and medication	No charge	
Intensive care unit and other special units, general and special duty nursing	No charge	
Laboratory and diagnostic imaging	No charge	

2013 BENEFITS SUMMARY

AVMED HMO PLANS - SCHEDULE OF BENEFITS		
SCHEDULE OF BENEFITS	AVMED HMO HIGH	AVMED HMO LOW
	COST TO MEMBER	COST TO MEMBER
CHIROPRACTIC	$15 per visit	$30 per visit
PODIATRY	$15 per visit	$30 per visit
OUTPATIENT SERVICES		
Outpatient surgeries, including cardiac catheterizations and angioplasty	No charge	No charge
OUTPATIENT DIAGNOSTIC TESTS		
Complex radiological imaging (CT, MRI, MRA, PET and Nuclear Cardiac Imaging) Mammogram	No charge	No charge
Other diagnostic imaging tests and Laboratory	No charge	No charge
Mammogram	No charge	No charge
EMERGENCY SERVICES		
An emergency is the sudden and unexpected onset of a condition requiring immediate medical or surgical care.	Co-payment waived if admitted. Plan must be notified within 24 hours of emergency inpatient admission.	Co-payment waived if admitted. Plan notification required within 24 hours of emergency inpatient admission.
Emergency svces at participating hospitals	$25 co-payment	$100 co-payment
Emergency services - non-participating hospitals, facilities and/or physicians	$25 co-payment	$100 co-payment
URGENT /IMMEDIATE CARE		
Medical Services at a participating Urgent/Immediate Care facility or svces rendered after hours in your Primary Care Physician's office	$25 co-payment	$50 co-payment
Medical Services at a participating retail clinic	$15 co-payment	$30 co-payment
Medical Services at a non-participating Urgent/ Immediate Care facility or non-participating retail clinic	$50 co-payment	$50 co-payment
AMBULANCE		
When pre-authorized or in the case of emergency	No charge	No charge
DRUG AND ALCOHOL REHABILITATION PROGRAMS		
Outpatient	$15 per visit	$30 per visit
Inpatient	No charge	$150 per day, first 3 days p/admission. No charge thereafter.
MENTAL / NERVOUS DISORDERS		
Outpatient	$15 per visit	$30 per visit
Inpatient	No charge	$150 per day, first 3 days p/admission. No charge thereafter.

2013 BENEFITS SUMMARY

AVMED HMO PLANS - SCHEDULE OF BENEFITS		
SCHEDULE OF BENEFITS	AVMED HMO HIGH COST TO MEMBER	AVMED HMO LOW COST TO MEMBER
PHYSICAL, SPEECH, RESPIRATORY & OCCUPATIONAL THERAPIES		
Short-term Physical, Speech, Respiratory and Occupational therapy for acute conditions. Coverage is limited to 60 visits combined per Calendar year	$30 per visit	$45 per visit
DURABLE MEDICAL EQUIPMENT Equipment includes but not limited to: Hospital beds, walkers, crutches,wheelchairs	Benefits limited to $2000 per Calendar Year	Benefits limited to $500 per Calendar Year
	$50 per episode of illness	$50 per episode of illness
DIAGNOSIS AND TREATMENT OF AUTISM SPECTRUM DISORDER		
Applied Behavioral Analysis (ABA)	$15 per visit	$30 per visit
Physical, Speech, Occupational Therapy	$15 per visit	$30 per visit
Calendar Year Maximum: Lifetime Maximum:	$36,000 $200,000	$36,000 $200,000
PRESCRIPTION MEDICATION BENEFIT — RETAIL, 30 DAY SUPPLY (*INCLUDES CONTRACEPTIVES)		
Generic	$15 co-payment	$20 co-payment
Preferred Brand	$25 co-payment	$35 co-payment
Non-Preferred Brand	$35 co-payment	$55 co-payment
NOTE: Specialty Drugs (example: self injectables, etc.) - Available only on a 30-day supply basis from a specialty pharmacy for the applicable copayment.		
PRESCRIPTION MEDICATIONS - MAIL-ORDER, 90 DAY SUPPLY (*INCLUDES CONTRACEPTIVES)		
Generic	$30 co-payment	$40 co-payment
Preferred Brand	$50 co-payment	$70 co-payment
Non-Preferred Brand	$70 co-payment	$110 co-payment
DEFINITIONS: Generic - medication on the Prescription medication list. Preferred Brand - medication designated as preferred on the prescription medication list with no Generic equivalent. Non-Preferred Brand - medication with a Generic equivalent and/or medication designated as non-preferred on the Prescription medication list.		
BRAND ADDITIONAL CHARGE - When Brand is requested and a generic equivalent is available: Member pays the difference between the cost of the Brand medication and Generic medication, plus the Non-Preferred Brand co-payment.		
* There is no co-payment for Generic contraceptives, in accordance with provisions of the Patient Protection and Affordable Care Act (PPACA).		
PRIOR AUTHORIZATION IS REQUIRED FOR SPECIFIC COVERED SERVICES INCLUDING, BUT NOT LIITED TO: All Inpatient Services, Observation Services, Residential Treatment, Outpatient Surgery, Intensive Outpatient Programs, Complex Radiological Imaging (CT, MRI, MRA, PET and Nuclear Cardiac Imaging), Non-Emergency Ambulance, Dialysis Services, Transplant Services, use of Non-Participating Providers, Select Medications Including Injectables		